AFFIDAVIT OF COMPLETION OF PHARMACY TECHNICIAN EDUCATION/TRAINING PROGRAM

Indiana Professional Licensing Agency
Indiana Board of Pharmacy
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
317-234-2067
http://www.in.gov/pla

I, _____, do solemnly swear or affirm under
(Name of Qualifying Pharmacist)

the penalties of perjury, that _____ has
(Name of Pharmacy Technician)

completed the following Indiana Board approved training and education

program: _____.
(Name of Indiana Board Approved Program)

_____
Signature of Qualifying Pharmacist

_____
Pharmacist License Number

_____
Date

_____
Signature of Pharmacy Technician

_____
Technician-in-Training Permit Number
(*if applicable*)

_____
Date